EDITORIALS

Deregulation and Governance in Health Care

AS THIS ISSUE goes to press a new Congress will have convened and a new President is about to be inaugurated. It is too early to sense what all the consequences may be. Some expect that they will be dire, and destructive of progress—social or otherwise. Others are convinced that we are on the threshold of a rejuvenated America destined to reaffirm its historic industrial, social, economic and political preeminence in an all too confused and contentious world. But all seem to share a hope or an expectation that things will somehow be different, whether for better or worse.

And there is a whiff of deregulation in the air. In all fairness it got under way during the previous administration and appears likely to continue under the new one. But whether or to what extent it can or will be applied in health care remains to be seen. Any deregulation in health care will not be easy. For more than a decade regulation of the health care enterprise by government has become increasingly institutionalized through gradual but apparently inexorable enactment and implementation of a series of federal laws which affect virtually every facet of health and health care. There are now literally hundreds of federal agencies with rules pertaining to medical education, research, patient care and other aspects of health, and the 50 states and thousands of local communities have also contributed their share of legislation and regulations. It would seem that something like a critical mass of regulation may already be in place and that any significant deregulation of health care may now be difficult indeed.

Yet some deregulation of the health care enterprise is a consummation devoutly wished by most physicians. A large number would agree that many laws and regulations, no matter how well intentioned, have turned out to create more problems than they solve and to add substantially and unproductively to health care costs. Yet some regulation or governance is clearly necessary. The problem which has yet to be solved is how an interdependent system, with autonomous and independent parts which are changing all the time, can best be governed. Fixed laws and cumbersome regulations too often are proving both inadequate and inappropriate for governance of such a dynamic, changing, really natural social system. This appears to be a seminal problem for America as a whole, as the fine structure of its natural free society becomes ever more interrelated and ever more interdependent. The problem is a fundamental one and it just happens to be coming into focus most clearly in the health care enterprise where the evidence is accumulating that fixed laws and regulations are simply too insensitive and too sluggish to be compatible with rapid progress and change as it occurs in a dynamic and, if you will, natural social system.

Perhaps there is now an opportunity to recognize that a vital system such as the health care enterprise will simply not thrive in an artificial environment of restrictive laws and regulations which are external to it. Some relief is needed from these artificial initiatives and controls which are simply not working. But anarchy or complete absence of governance or control cannot be ex-

pected to work well either. Somehow the natural interrelationships and interdependencies must come to be recognized for what they are, and then dealt with more effectively and in greater collaboration with the autonomous and independent parts within the system that must do whatever is to be done. This is a formidable challenge for a rejuvenating America, and for its health care enterprise, since this is where this fundamental problem seems first coming into sharpest focus.

To make a start it is first necessary for all concerned to recognize the problem for what it is. Then steps can be taken to disengage the health care enterprise from some of its present unnatural legal and regulatory shackles, and at the same time to develop a more natural and more sensitive governance of the system which will involve the important forces within it. Perhaps this process can begin under the new Congress and the new President. One can hope that it will.

—MSMW

Prognosis After Myocardial Infarction

PATIENTS ADMITTED to coronary care units (CCU) with acute myocardial infarction have an inhospital mortality of 15 percent to 20 percent. While this represents an improvement over the 25 percent to 30 percent mortality in the era before CCU's it is unlikely that further substantial reductions in early mortality will occur until effective therapy to limit infarct size becomes readily applicable, perhaps even in the prehospital phase of the infarction. Current areas of interest in the management of patients surviving the initial stay in hospital involve the identification of subsets of patients, who are at high, intermediate or low risk for future coronary events. With such identification, high-risk patients could be offered aggressive medical or surgical therapy while potentially dangerous treatments and investigative procedures could be avoided in low-risk patients. As Kishpaugh and her co-workers indicate in their paper elsewhere in this issue, there is an important "need for physicians to know those factors which affect long-term prognosis of patients with ischemic heart disease." Although these authors have presented little new information on how physicians can recognize these factors, their report has merit in that it reemphasizes the magnitude of the problem we face in treating such patients (nearly 40 percent mortality during the five-year follow-up period.)

A number of studies have appeared in recent years that show the reliability of easily obtained clinical data in separating high-risk from low-risk survivors of acute myocardial infarction. The patient's age, heart size on admission (or discharge), findings on x-ray films of the chest and history of previous infarction were found to be the most powerful predictors of mortality in the six-year follow-up study reported by Norris and colleagues.[1] The predictive value of the initial x-ray study of the chest alone, with attention to cardiothoracic ratio and pulmonary venous congestion, is excellent according to the recent study of Battler and co-workers.[2] These data simply indicate that the extent of damage to the left ventricle, both from the index event and from prior infarcts, is a fundamental determinant of long-term survival. More complicated and expensive tests to assess ventricular function have confirmed these findings.[3] The additional, and possibly independent, risk factor of ventricular ectopy detected by 6- to 24-hour ambulatory electrocardiography has also received considerable attention, beginning with the initial reports from the Coronary Drug Project.[4,5] Combining the two factors of pronounced left ventricular damage and late hospital-phase arrhythmias, one can separate accurately the high-risk from the low-risk patients.[6,7] Even coronary angiography and left ventriculography, though obviously the gold standards for assessing prognosis in ischemic heart disease, do not seem to provide additional, clinically useful information.[8]

Within the group of patients having no late arrhythmias in hospital and minimally damaged ventricles, there are some who remain at excessive risk of recurrent ischemic events. Low-level treadmill exercise testing, done as early as two weeks after the acute infarction, gives promise of identifying these patients.[9-14]

Kishpaugh and her colleagues have shown the continuing high mortality in survivors of the acute phase of myocardial infarction in the era of coronary care units, and the studies cited above have pointed the way towards a reasoned therapeutic approach to the various subgroups of patients who comprise these mortality data.